DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HEALTH AND RECOVERY SERVICES ADMINISTRATION
Olympia, Washington

To:	Rural Health Clinics Managed Care Organizations	**Memorandum No: 07-68** **Issued:** November 09, 2007
From:	Douglas Porter, Assistant Secretary Health and Recovery Services Administration (HRSA)	**For information, contact:** 800.562.3022 or go to: http://maa.dshs.wa.gov/contact/prucontact.asp

Subject: Rural Health Clinics: Change in Payment for Certain Services Provided in an RHC

Effective for claims processed on and after October 29, 2007, the Health and Recovery Services Administration (HRSA) will no longer pay the encounter rate or enhancement payment to Rural Health Clinics (RHCs) for services provided to clients covered under the medical assistance programs listed in this memorandum. Only clients enrolled in Title XIX (Medicaid) or Title XXI (CHIP) are eligible for enhanced or encounter payments. When billing for services provided to clients eligible under the affected programs, providers must use their fee-for-service provider number. This affects claims and any adjusted claims with dates of service on and after January 1, 2007.

Which services are affected by this change?

For services provided to clients in the following programs, bill using your **fee-for-service** provider number.

Medical Coverage Group Codes (In Field 4)	Medical Coverage Group Definitions
F08	Children's Health Program
F09	Undocumented Aliens
G01	General Assistance
I01	Institution for the Mentally Diseased (IMD)
M99	Psychiatric Indigent Inpatient
P04	Pregnancy-Related
P05	Family Planning
S07	SSI-Related Undocumented Alien
W01, W02, and W03	ADATSA

Background Information

On January 1, 2007, HRSA published updated *Rural Health Clinic Billing Instructions*. These billing instructions state that claims for services provided to clients in state-only programs are not eligible for enhancement or encounter payments.

Billing Instructions Replacement Pages

Attached are replacement pages i-ii and G.3-G.6 for HRSA's *Rural Health Clinic Billing Instructions*.

How do I conduct business electronically with HRSA?

You may conduct business electronically with HRSA by accessing the WAMedWeb at http://wamedweb.acs-inc.com.

How can I get HRSA's provider documents?

To obtain DSHS/HRSA provider numbered memoranda and billing instruction, go to the DSHS/HRSA website at http://hrsa.dshs.wa.gov (click ***the Billing Instructions and Numbered Memorandum*** link). These may be downloaded and printed.

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Supplemental Payments for Managed Care Clients

Healthy Options enhancement payments for managed care clients

In addition to encounter rate payments and FFS payments, each RHC also receives a supplemental payment each month for each client assigned to them by an MCO. These payments, called "HO enhancements," are intended to make up the difference between the MCO payment and a clinic's encounter rate. The HO enhancements are not billed by the clinics; payments are generated from client rosters submitted to HRSA by the MCOs. Payment is sent directly to the RHCs.

RHC delivery enhancement payment

In order to encourage the RHC to provide maternity services to its assigned managed care clients and to offset the additional costs incurred by the RHC for these services, HRSA makes a payment to the clinic when a qualified RHC provider performs a delivery for a managed care client assigned to the clinic. This payment is known as the "RHC delivery enhancement." If the client's Medical ID Card has a "BHP+" indicator in the HO column, HRSA pays the clinic an additional payment for the delivery known as the "S-kicker enhancement."

HRSA pays a clinic an RHC delivery enhancement and, if applicable, the S-kicker enhancement only when either of the following scenarios is met:

1. The RHC provider **actually performs the delivery and the RHC** (or any provider under the same tax ID as the RHC) **is the client's assigned Primary Care Provider (PCP).**

HRSA does not pay the RHC an RHC delivery enhancement payment for a managed care client assigned to the RHC when a provider who is not affiliated with the client's assigned clinic performs the delivery or when the RHC provider assists at delivery.

-OR-

2. The **RHC** (or any provider under the same tax ID as the RHC) **is the client's assigned Primary Care Provider (PCP) and the RHC is fully financially liable for the cost of the delivery**.

To be considered fully financially liable, the RHC must pay the provider who performs the delivery 100% of the cost of the delivery from its own funds. Participation in "risk pools" **does not** constitute being fully financially liable. The RHC Program Manager will review the RHC's contract with the managed care organization in order to determine whether the RHC is fully financially liable. HRSA will not pay a delivery or S-kicker enhancement without this determination **and** prior approval from the RHC Program Manager.

How do I bill for an RHC delivery enhancement?

Bill HRSA for the RHC delivery enhancement payment using either

- The delivery-only CPT code 59409 with modifier UC; or
- CPT code 59514 with modifier UC.

Modifier UC is a payer-defined modifier. HRSA defines modifier UC as "FQHC/RHC Service." Use the ICD-9-CM diagnosis code V68.9 (unspecified administrative purpose).

How do I bill for the S-kicker enhancement?

Submit a separate claim using CPT code 59899 with modifier UC. Enter the following information:

- In field 33, enter the appropriate FQHC/RHC managed care provider ID number (*PIN#*), beginning with 759, and the plan provider number (*GRP#*), beginning with 750; and
- In field 26, enter the Patient's Account No.

Payment for Services Provided to Clients not Eligible for RHC Payment

For services provided to clients in programs not eligible for RHC payment, bill using your FFS provider number regardless of the type of service performed. HRSA does not pay the encounter rate or the enhancement for clients enrolled in these programs (see the following grid and sample Medical ID Card).

RHC clients who present Medical ID Cards with one of the following medical coverage group codes in field 4 do **not** qualify for the encounter rate or the enhancement:

Medical Coverage Group Codes (In Field 4)	Medical Coverage Group Definitions
F08	Children's Health Program
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P04	Pregnancy-Related
P05	Family Planning
S07	SSI-Related Undocumented Alien
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Sample of Medical ID Card for State-Only Client

AU ID:	4246742	**Program:**	General Assistance (GA)
Review End Date:	09/2007	**Coverage Group:**	Med Care Svc Unemployed/GA Unemployed/GA Regular/GA-A/B/D (G01)
Head of Household:		**HoH Client ID:**	
Primary Language:	English (EN)	**NSA?**	No (N)

Medical ID Card Details

Central Reprint Request | Local Reprint Request | View with New Details

Issuance Date:	10/31/2006		
Current Status:	Issued (ID)	**Status Date:**	10/31/2006
Coverage Begin Date:	10/16/2006	**Coverage End Date:**	11/30/2006

Patient Identification Code (PIC)				Medical Coverage Information							
Initials	Birthdate	Last Name	TB	Insurance	Medicare	HMO	Detox	Restriction	Hospice	DD Client	Other
	032376		A								

GA

Scope of Care

NO OUT OF STATE CARE

222 ELECTRIC
OLYMPIA WA 9850

Under what circumstances does HRSA change RHC payment rates?

Changes in Scope of Service

A change in scope of service is defined as a change in the type, intensity or duration of a service provided by the clinic. The RHC must request an adjustment to its encounter rate to reflect a change in scope of service. For example, if a clinic adds an encounter service that was not included in its base years' cost reports, or no longer provides a service that was included in the base years' cost reports, the clinic must request a change in scope of service. For instance, a clinic that begins offering a psychologist's services has experienced a change in the type of services provided and may qualify for a rate adjustment. ***A change in costs alone does not warrant a change in scope of service.***

The following steps are necessary to request a change in scope of service:

- The clinic must notify the RHC Program Manager in writing of the change, including the effective date of the change and all other relevant details.

- The clinic must provide an updated covered services form to the RHC Program Manager, with the service in question marked appropriately and the effective date included.

- If the change is the addition of a service, HRSA adjusts the encounter rate by an interim amount to reflect the difference in costs caused by the addition of the service. HRSA determines the interim amount by examining the average costs of the other clinics providing similar services and/or reviewing a cost estimate, if available, provided by the clinic requesting the change.

- HRSA uses the first Medicare-audited cost report that includes a full year of costs of the new service to determine the final adjustment amount. This amount replaces the interim amount in the rate adjustment, retroactive to the original effective date of the service change. HRSA reconciles all encounters paid at the interim amount by making a lump-sum payment to the clinic.

- If the change is the subtraction of a service, HRSA determines the corresponding decrease in costs and reduces the encounter rate accordingly. To reconcile encounters paid at the higher rate after discontinuing the service, the clinic sends a lump-sum payment to HRSA. Payment arrangements are made with the RHC Program Manager.

- The clinic's enhancement rate will be adjusted accordingly, either increasing to reflect the addition of a service or decreasing due to the subtraction of a service.